DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2011 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 155719			LDING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/22/2011	
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER	•	3623 E	ADDRESS, CITY, STATE, ZIP CO SR 16 (, IN47922	ODE	
(X4) ID PREFIX TAG K0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	and State Licenconducted by the Department of accordance with Survey Date: In Facility Number Provider Number AIM Number: Surveyor: Bridge Safety Code Spafety C	th 42 CFR 483.70(a). 1/22/11 r: 000559 er: 155719 100267170 get Brown, Life ecialist ety Code survey, emorial Health Care and not in th Requirements for caid, 42 CFR 0(a), Life Safety the 2000 edition of re Protection FPA) 101, Life Safety apter 19, Existing ecupancies and 410	KO	0000	Re: POC for the annu George Ade Memoria Care Center, Brook, I Survey Event ID 6VU Dear Miriam Buffingto This letter is in regard aforementioned surve conducted on Novem 2011. The following plan of being submitted as ou of substantial compliant further submit that this substantial compliant 22 nd day of Decemb After that time we are the Indiana State Dep Health conduct a follo and/or accept this info paper compliance to of findings and stop any proposed or implement remedies that have be presented to date. If you have any quest further information, ca 219-275-2531 or fax 219-275-7472, and we available to assist you possible. Thank you,	al Health N. C21 on: ds to the ey that was ber 22, correction is ur allegation ance. We s facility is in the as of the ther 2011. The requesting partment of the partment of t	
	1	one story facility was mined to be of Type II (222)			W R Scott James, HF GAMHCC	FA	
LABORATOR	W DIDECTORIC OF PRO	WINED CHIDDLIED DEDDESENTATIVE'S SI	ICNI A TELEDI		TITLE		(V6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6VUC21

Facility ID:

000559

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155719			LDING	NSTRUCTION 01	(X3) DATE COMPL 11/22/2	ETED	
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER	•	3623 E	DDRESS, CITY, STATE, ZIP CODE SR 16 , IN47922	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE
	alarm system we detection in the spaces open to facility has a call had a census of this survey. Quality Review by Code Specialist-Media The facility was compliance with aforementioned.	he facility has a fire with smoke e corridors and the corridors. The apacity for 70 and f 56 at the time of Robert Booher, Life Safety dical Surveyor on 12/01/11.			This plan of correction is prepared and submitted sole because it is required by the and Federal law, and not be the Provider agrees with the allegations made in the survidocument. In fact, the alleg deficiencies do not, either individually or collectively, demonstrate the facility's resident's health, safety or welfare is compromised or this Provider is incapable of rendering all necessary and beneficial nursing care and services. This plan of correction consiste Provider's allegation of compliance. Completion dates are provided because they are required become action, in the conthe survey process. To the possible, permissible dates, dates after the surveyors leffacility, were assigned.	e State cause erey ed hat titutes led ly to text of extent i.e.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		nstruction 01	(X3) DATE :	ETED	
		155719	B. WINC	3		11/22/2	011
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER		3623 E S	DDRESS, CITY, STATE, ZIP CODE SR 16 , IN47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0021 SS=E	Any door in an exi enclosure, horizon hazardous area er by devices arrange such doors by zon upon activation of: a) the required may b) local smoke det smoke passing threquired smoke det smoke passing threquired smoke det smoke passing threquired smoke details. The control of the automatic state of the automatic state of the sare of the sare of the control of the automatic closi with 7.2.1.8. The practice affects details of the control	t passageway, stairway tal exit, smoke barrier or nclosure is held open only ed to automatically close all e or throughout the facility anual fire alarm system; ectors designed to detect rough the opening or a etection system; and orinkler system, if installed. 3.2 vation and acility failed to are door sets was comatically close. equires fire barrier f closing or ang in accordance this deficient visitors, staff and the EC and MS e: e: vation with the arector on 11/22/11 ane door in the the ear the dining room upon activation of ystem by the	КО	021	The door hold magnet has been replaced as of 11/30/11 is functioning properly. The panel system has been chect and all magnetic door holders functioning properly as activately the alarm system(s). The magnetic door releases are visually checked with each altest, to see that they are functioning properly, so as to prevent reoccurrence. Any repairs/changes are complete upon review of a defective detective the device during normal maintenance and testing of the system(s) to prevent further occurrences. Done as of 11/30/2011.	e fire ked s are ated e arm ed evice. or	11/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		01	(X3) DATE S COMPL	ETED
		155719	B. WINC			11/22/2	JII
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER		3623 E S	DDRESS, CITY, STATE, ZIP CODE SR 16 IN47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K0029 SS=E	explain why the the door open is upon activation 3.1–19(b) One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1 Based on observinterview, the free sure unatten and trash recept capacity exceed capacity within are stored in a a hazardous are compartments. practice a affect	em option is used, the areas on other spaces by smoke and doors. Doors are on-rated or field-applied nat do not exceed 48 inches the door are permitted. vation and acility failed to ded soiled linen otacles with a total ding 32 gallons any 64 square foot room protected as ea in 1 of 8 smoke This deficient ts visitors, staff ts on the MS unit.	K0	029	Barrels have been removed from the cited rooms, and are no longer use any resident rooms. Barrels of 2 yellow size will no longer be a in resident rooms for isolation procedures. Containers of procedures. Containers of procedures are commended size have been ordered to not exceed the recommended size for resident room use. Containers the correct size will now be unfor isolation procedures. This prevent further recurrence. The Housekeeping supervisor and DON or designee will be responsible to see that the correct size will now be unto the correct size will be responsible to see that the correct size will be responsible to see that the correct size will be responsible to see that the correct size will be responsible to see that the correct size will be responsible to see that the correct size will be responsible to see that the correct size will size the correct size will be responsible to see that the correct size will size th	ed in 8-32 used n roper of ze of sed s will	12/22/2011

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Event ID:

6VUC21 Facility ID:

000559

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719	(X2) MUI A. BUILD B. WING		o1	(X3) DATE S COMPLI 11/22/20	ETED
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	Р.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
K0048 SS=C	at 1:40 p.m., tw soiled linen and were observed resident room of The receptacles full and had the 32 gallons. The closing device, director said at observation, th for special isola soiled linen col 3.1–19(b) There is a written patients and for the of an emergency. Based on record observation and facility failed to complete fire pwhich included extinguishers a within the facility protection of 50 the event of an 19.2.2.2 requires	color trash and lection. Idention trash and lection. Idention for the protection of all leir evacuation in the event 19.7.1.1 dereview, definition in the event provide a rotection plan the use of fire and evacuation sites ty for the for the form of 56 residents in emergency. LSC less a written health of fire safety plan	K00)48	items are used in isolation procedures. i.e.: containers This is done of 12/22/2011. The fire policurrent with staff members availed by the for proper use. Proper fire extinguishers are available throughout the facility with protypes as required. All extinguishers are checked on a monthly base for proper condition and located. In-service provided on 12/8/2011, contained.	cy is ware licy chen low ers oper chers sis	12/06/2011

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Event ID:

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If continuation sheet

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				(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155719		. BUILE	DING	01	COMPL 11/22/2		
		1001 18	В.	. WING			1 1/22/2	VII	
NAME OF I	PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE			
CEOBO		HEALTH CARE CENTER		- 1	3623 E S	SR 16 , IN47922			
						, IIN+1322			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	,	D	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULI LISC IDENTIFYING INFORMATION		Р	REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
	(1) Use of alarn		/			proper use of fire extinguish	ers.	2	
	(2) Transmission of alarm to the					The			
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \					Maintenance supervisor or			
	fire departmen (3) Response to					designee will maintain and c each fire extinguisher throug			
	(4) Isolation of					the facility on a monthly basi			
	, ,	of immediate area				assure proper and functiona	I fire		
	(6) Evacuation					extinguishers are in place. A			
	l ` '	OI SIIIUKE				found to not be in proper wo order will be replaced	rking		
	compartment (7) Preparation	of floors and				immediately to avoid further			
	building for evaluation					concern.			
	(8) Extinguishn					This is don of 12/6/2011.	e as		
	_	oractice affects all				UI 12/0/2011.			
	·								
	residents in the	e iacility.							
	Findings includ	le:							
		rvation with the							
		irector on 11/22/11							
		a.m. and 1:50 p.m.							
	three types of I								
	_	were provided for							
		ity. Based on a							
		acility's written Fire							
		1/22/11 at 2:45							
	p.m. with the n	naintenance							
	director, the pl	an did not address							
	the use of the A	ABC type fire							
	extinguishers,	deionized water fire							
	extinguishers a	and the K class fire							
	extinguishers I	ocated in the							
	facility. There	was no evidence of							
	training for the	eir use. In addition,							
	when the cook	was interviewed on							
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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719		A.	2) MULTIPLE COI BUILDING WING	NSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/22/2011				
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3623 E SR 16 BROOK, IN47922						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FUL LSC IDENTIFYING INFORMATIC		ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODUCT TAG		ATE	(X5) COMPLETION DATE			
	how she would occurring on a napkins located kitchen near he would extinguit two K class fire located in the klocated above extinguisher gadirection for it not have been a napkin fire. The director agreed observation, in review; the fire	stack of cloth d on a shelf in the er, she said she sh it using one of extinguishers kitchen. A placard each K class ave specific s use which would appropriate for a le maintenance l at the time of terview and record plan was not more training would								
K0050 SS=C	varying conditions shift. The staff is f is aware that drills routine. Responsi conducting drills is competent person exercise leadershi conducted betwee announcement manudible alarms. Based on recordinterview, the form	s who are qualified to p. Where drills are in 9 PM and 6 AM a coded by be used instead of 19.7.1.2 d review and	d	K0050	 Fire drills very now be varied more than the current practice as noted. 		12/06/2011			
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155719	B. WIN	G		11/22/2	011
NAME OF E	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				3623 E			
GEORGE	E ADE MEMORIAL	HEALTH CARE CENTER		BROOK	X, IN47922		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	· Fire drills a		DATE
	_	e past 4 quarters.			conducted on all three (3) sh	_	
		practice affects all			as required in varying times		
	occupants.				to not provide a notable patte	ern of	
					predictability.		
	Findings includ	de:			 The variation be ongoing to prevent further 		
					concerns. Drill times will var		
		iew of Fire Drill			with each quarterly drill.	-	
	1 -	ne maintenance			· Administrate	or or	
		/22/11 at 2:55			designee and Maintenance supervisor will be responsible	e to	
	p.m., third shif	ft (11:00 p.m7:00			see that the drills are conduc		
	a.m.) drills wer	e conducted at 4:30			appropriately.		
	a.m., 5:00 a.m	., 5:30 a.m. and			· This is done	e as	
	5:45 a.m. durii	ng the past year.			of 12/6/2011.		
	Second shift (3	:00 p.m11:00					
	p.m.) drills wei	re done at 3:15 p.m.					
	(twice), 3:17 p.	.m. and 3:35 p.m.					
	during the pas	t year. The					
	maintenance d	irector agreed at					
	the time of rec	ord review, there					
	wasn't much va	ariation in the times					
	training was co	onducted each shift.					
	3.1-19(b)						
	3.1-51(c)						

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719		(X2) MI A. BUII B. WIN	LDING	onstruction 01	(X3) DATE COMPL 11/22/2	ETED
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER	•	3623 E	ADDRESS, CITY, STATE, ZIP CODE SR 16 (, IN47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	(X5) COMPLETION DATE
K0062 SS=E	Required automat continuously main condition and are periodically. 19. NFPA 25, 9.7.5 Based on observinterview, the frequire of 1 k sprinkler heads obstructions to NFPA 25, 2–2.1 unacceptable of spray patterns further NFPA 1 Sprinkler System requires the thresprinkler deflects to age should more. This defaffects 4 occup findings included affects 4 occup findings included at 12:15 p.m., the kitchen stolocated 10 inches sprinkler head protection for the maintenance did time of observations.	ic sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, and facility failed to ditchen storage is was free of a spray patterns. 1.2 requires abstructions to shall be corrected. 3, Installation of	KO	0062	The following information provided explain reasoning for the sprinkler installation in the pantry area. Section 5-5 NFPA 13 is dealing with clearance to storage, which case does not pertain to. The maker's footprint is less than sq. ft. (22 ½" wide x 24" deep with the head located approximately in the "quarter point" of the ice maker (see attached sketch). Figure A.5.5.5.1 pertains to the sprapattern of a Standard Spray Upright or Pendant Sprinkler The full development of the sprinkler pattern extends at 4'-0" radius from the sprinkled distance of 18" below the deflector. In this instance, the deflector is 11" from the top ice maker and approximately from the farthest edge of the maker. The full development the sprinkler pattern at 11" be the deflector is at a radius of 29.33" from the center of the sprinkler – well outside the footprint of the ice maker. This room is sq. ft. (8'-8" x 10'-11"). With horizontal distance of only 3 from the discharge of the fire	ng s the a. 6.6 of this lee ice 4 4 p) from the control of the con	12/05/2011
	NFPA 25, 9.7.5 Based on obserinterview, the fensure 1 of 1 ksprinkler heads obstructions to NFPA 25, 2-2.1 unacceptable ospray patterns Further NFPA 1 Sprinkler Systerequires the thsprinkler deflects and the storage should more. This defaffects 4 occup Findings included Based on obsermaintenance diat 12:15 p.m., the kitchen stolocated 10 inch sprinkler head protection for the maintenance ditime of observations.	evation and facility failed to sitchen storage is was free of spray patterns. 2 requires betructions to shall be corrected. 3, Installation of ims, in 5–5.6 e clearance between ctors and the top of ibe 18 inches or ficient practice pant in the kitchen. Ite: Evation with the firector on 11/22/11 the ice machine in rage room was fires from the only providing the room. The firector said at the ation, he did not inkler head was less	K	0062	information provided explain reasoning for the sprinkler installation in the pantry area. Section 5-5 NFPA 13 is dealing with clearance to storage , which case does not pertain to. The maker's footprint is less than sq. ft. (22 ½" wide x 24" dee with the head located approximately in the "quarter point" of the ice maker (see attached sketch). Figure A.5.5.5.1 pertains to the spray upright or Pendant Sprinkler. The full development of the sprinkler pattern extends at 4'-0" radius from the sprinkled distance of 18" below the deflector. In this instance, the deflector is 11" from the top ice maker and approximately from the farthest edge of the maker. The full development he sprinkler pattern at 11" be the deflector is at a radius of 29.33" from the center of the sprinkler – well outside the footprint of the ice maker. This room is sq. ft. (8'-8" x 10'-11"). With horizontal distance of only 3:	s the a. a. a. a. a. a. a. a. a. a	12/05/2

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI	IPLE CON	STRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155719			A. BUILDIN	lG	01	11/22/2	
		1337 13	B. WING			1 1/22/20	311
NAME OF P	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE		
GEORGE	ADE MEMORIAL	HEALTH CARE CENTER	3623 E SR 16 BROOK, IN47922				
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX CRC TAG		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG			17	AU	of approximately 51 Gallons I	Per	DATE
	allowed between a sprinkler head and an obstruction.				Minute (GPM), resulting in a	0.	
					sprinkler density of 0.50 GPM/sq.		
	2.1.10(b)				ft – far beyond what is require for a dry food storage room	ed	
	3.1-19(b)				(Ordinary Hazard, Group I		
					occupancies require a densit		
					0.15 GPM/sq. ft.). If the sprir		
					head in the Food Storage roo were ever to activate, the are		
					would literally be flooded and		
					fire very quickly extinguished		
					 We would a that this information be review 	_	
					and accepted as a reasonabl		
					application for the sprinkler	,	
					location. (See attached diagramme). The	am)	
					Maintenance supervisor and/	or	
					Administrator will be respons	ible	
					to see that this is maintained. This is done		
					of 12/5/2011.	: a5	
K0064		guishers are provided in all					
SS=D	•	ancies in accordance with 5, NFPA 10					
	Based on obser	vation and	K0064	4	The area are the noted extinguishers has be		11/30/2011
	interview, the f				cleared to provide ample acc		
	ensure 2 of 2 p				to the devices at all times.		
	_	n the kitchen were			Staff has be instructed to maintain this acc		
	•	ole. NFPA 10, the			space at all times.	J C SS	
	Standard for Po				· Area is to		
		Chapter 1, 1-6.3			remain accessible and items	that	
		uishers shall be			may prevent this have been removed to prevent reoccurre	ence.	
		located where they			· Dietary Mar		
	will be readily a				and/or designee will be	-	
		ailable in the event			responsible to see that the ar maintained at all times.	ea is	
	of fire. This de	encient practice			This is done	as	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	155719	A. BU	ILDING	01	COMPL 11/22/2	
		1991 18	B. WII			11/22/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CEODOS		HEALTH CARE CENTER		3623 E	SR 16 (, IN47922		
			-	<u> </u>	, IINT/ 322		
(X4) ID		TATEMENT OF DEFICIENCIES CV MUST BE REPORDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
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1710	affects 4 kitche				of 11/30/2011.		2.112
	arrects 4 kitche	iii Staii.					
	Findings include:						
	Based on obser	vation with the					
		irector on 11/22/11					
	at 12:20 p.m.,	, ,					
	class fire exting	· · · · · ·					
	_	kitchen; one behind					
	a stack of empt						
	=	e north exit door					
		ehind a five foot					
		service cart. The					
	-	irector agreed at					
		ervations, the use					
		nguishers could be					
	impeded by the	ese obstructions.					
	3.1-19(b)						
110055	Called lines and the	ala adlastica vas este elecció					
K0075 SS=E		sh collection receptacles do (121 L) in capacity. The					
33-E	_	f container capacity in a					
	room or space doe	es not exceed .5 gal/sq ft					
		capacity of 32 gal (121 L) is					
		in any 64 sq ft (5.9-sq m) d linen or trash collection					
		apacities greater than 32					
	gal (121 L) are loc	ated in a room protected as					
		when not attended.					
	19.7.5.5	nuation and	l v	.0075	· Barrels hav	'e	12/22/2011
	Based on obser		"	.0073	been removed from the cited	_	12/22/2011
	interview, the f				rooms, and are no longer use	ed in	
		ded soiled linen			any resident rooms.	0 22	
	and trash recep	otacles with a total			Barrels of 2	:Ծ-3∠	
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155719	B. WIN	G		11/22/2	U11
NAME OF I	PROVIDER OR SUPPLIER	}		1	DDRESS, CITY, STATE, ZIP CODE		
05050	- 455 45465141	LIEN THEAT		3623 E			
GEORGE	E ADE MEMORIAL	HEALTH CARE CENTER		BROOK	I, IN47922		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)	+	TAG	yellow size will no longer be	ueod	DATE
	capacity exceeding 32 gallons capacity were not stored within any 64 square foot area in 1 of 8				in resident rooms for isolation		
					procedures. Containers of p		
					size have been ordered to no		
	smoke compar				exceed the recommended six	ze	
		ice a affects visitors,			for resident room use. Containers	of	
		sidents on the MS			the correct size will now be u	-	
	unit.				for isolation procedures. This	s will	
					prevent further recurrence. The		
	Findings includ	de:			Housekeeping supervisor an	d	
					DON or designee will be	~	
	Based on obse	rvation with the			responsible to see that the co	orrect	
	maintenance d	irector on 11/22/11			items are used in isolation		
	at 1:40 p.m., t	wo 28 to 32 gallon			procedures. i.e.: containers This is done	28	
	soiled linen an	d trash receptacles			of 12/22/2011.	<i>,</i> 40	
	were observed	sitting side by side					
	through the op	en resident room					
	door of room 2	24. The receptacles					
	were half or m	ore full and had the					
	capacity for 28	to 32 gallons. The					
	maintenance d	irector said at the					
	time of observ	ation, the					
	receptacles we						
	-	and soiled linen					
	collection.						
	3.1-19(b)						
	311 13(3)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					ľ í	ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155719	B. WIN	G		11/22/2	011
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER		3623 E	ADDRESS, CITY, STATE, ZIP CODE SR 16 (, IN47922		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID		1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE.	DATE
K0143 SS=E	Transferring of oxy	ygen is: n any portion of a facility					
	wherein patients a	are housed, examined, or ration of a fire barrier of					
		is mechanically ventilated, as ceramic or concrete					
	transferring is occ the immediate are accordance with N Compressed Gas Based on obser interview, the fensure liquid of 1 sprinklered storage/transfestored in an are fixtures were a inches) above to 8–3.1.11.1 requesting nonflammable with 4–3.1.1.2(a)(4) fixtures, switch oxygen storage installed in fixed than 5 feet about avoid physical deficient practimore staff and	Association. 8.6.2.5.2 rvation and facility failed to xygen stored in 1 d oxygen er locations, was ea where electrical t least 5 feet (60 the floor. NFPA 99, uires storage for gases shall comply NFPA 99, requires electrical tes and outlets in e locations be ed locations not less ove the floor to	K)143	The switch been relocated to the correct height of not less than five (5 above the floor. The correct permanent in nature and wor not be required to be done at The moving the switch meets the current as required. The Maintenance supervisor will responsible to see that this is maintained. Done as of 12/6/2011.	is in the second of the second	12/06/2011

000559

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155719		A. BUII	LDING	NSTRUCTION 01	(X3) DATE S COMPL 11/22/20	ETED	
NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER			B. WIN	3623 E 3	DDRESS, CITY, STATE, ZIP CODE SR 16 , IN47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	at 12:10 p.m., room had four liquid oxygen s in the room wit light switch on above the floor director said at observation, he	e: vation with the rector on 11/22/11 the oxygen storage 181 liter capacity torage tanks stored h one electrical the wall 48 inches . The maintenance					
K0144 SS=F		spected weekly and ad for 30 minutes per ace with NFPA 99.					
	1 emergency go conducted usin following meth	acility failed to nly load test for 1 of enerators was g one of the three	K)144	form for the "GAS" generator been revised to include the operating temperature as required. Currently the generator is run on a weekly basis to assure the operation the equipment.	has e	12/06/2011

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Event ID:

6VUC21

Facility ID:

000559

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2)	MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
AND PLAN	and Plan of Correction identification number: 155719		A. BU	JILDING	01	11/22/2	
		100718	B. W.			11/22/2	UII
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GEORGE	E ADE MEMORIAL	HEALTH CARE CENTER		3623 E S	SR 16 (, IN47922		
					., 11477 522		710
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	, The state of the	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE
	at not less thar	1 30% of the			· Continue t	0	
		ver Supply (EPS)			perform weekly and monthl	-	
		ng, or loading that			operation checks to assure generator is in operational	the	
	<u>-</u>	ninimum exhaust			condition as needed.		
	gas temperatur				· The		
	recommended				Maintenance supervisor an		
		Chapter 3-4.4.1.1			designee are responsible to that the generator is mainta		
	of NFPA 99 req	•			and operations recorded.	cu	
	·	rators serving the			· This is do	ne as	
		ctrical system to be			of 12/6/11.		
	in accordance v	•					
	Chapter 6-4.2						
	· ·	ator sets in Level 1					
	'	vice to be exercised					
	at least once m						
) minutes, using					
		owing methods:					
		ting temperature					
	· •	t not less than 30					
	percent of the						
	rating.	LI 5 namepiate					
	b. Loading that	maintains the					
	minimum exha						
		is recommended by					
	the manufactur	· ·					
	The date and ti						
		g shall be decided					
		pased on facility					
	· ·	is deficient practice					
	_ ·	residents, staff and					
	visitors.	. co.aciito, otali alia					
	1.3.00.3.						
	Findings includ	le:					
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	6VUC2	1 Facility I	D: 000559 If continuation	sheet Pa	ge 15 of 21

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155719		A. BUILI	DING	01	(X3) DATE S COMPLI 11/22/20	ETED	
	PROVIDER OR SUPPLIER		B. WING	3623 E S	DDRESS, CITY, STATE, ZIP CODE SR 16 IN47922		
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E.	(X5) COMPLETION DATE
	Based on review Generator Run maintenance regenerator with director on 11/p.m., the emergonal test record the percentage or minimum optemperature remaintenance dittime of record	v of the emergency Test Log and cords for the diesel the maintenance 22/11 at 1:30 gency generator of the monthly did not include of the load carried derating exhaust adings. The rector said at the review, he did not of the load temperature and there had					
K0147 SS=D	Code. 9.1.2 Based on obser interview, the f ensure 1 of 1 fl	vation and acility failed to exible cords were ubstitute for fixed (National), 1999 Edition, equires, unless	K0	147	 The cord had been removed and disposed and will no longer be used for cited equipment. Staff is awa that extension cords are not to used on any permanent use device. The use of extension cords is prohibited 	of r the re o be	11/23/2011

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STRIET ADDRESS, CITY, STATE ZIP CODE SURVING STRIET ADDRESS, CITY, STATE ZIP CODE SOCIED ADDRESS	AND PLAN OF CORRECTION IDENTIFICA		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 01	(X3) DATE S COMPL	
MAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER INTERPRETAY (PA-1)D SUMMARY STATEMENT OF DEFICIENCIES PREFIX (PA-CH DEFICIENCY MUST BE PURCEDED BY FULL TAG COrds and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 3 residents in the lobby smoke compartment. Findings include: Based on observation with the maintenance director on 11/22/11 at 12:30 p.m., an extension cord was plugged into the cord used to power the window air conditioner in the director of nurses office. The maintenance director said at the time of observation, extension cords were not approved for use in the facility. K0154 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a written policy SIMMARY STATEMENT OF DEFICIENCY. SCAPE ID PROFIX TAG SIMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SASTER 18 PREFIX TAG SASTER 18 PREFIX TAG TAG PREFIX TAG SASTER 18 SASTER 18 PREFIX TAG SASTER 18 SASTER 18 ID PROFIXES TAM OF CREMENTOR. DATE SASTER 18 SAST								
GEORGE ADE MEMORIAL HEALTH CARE CENTER GEORGE ADE MEMORIAL HEALTH CARE CENTER OX91D SLAMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LISC IDENTIFY NO. INFORMATION.) Cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 3 residents in the lobby smoke compartment. Findings include: Based on observation with the maintenance director on 11/22/11 at 12:30 p.m., an extension cord was plugged into the cord used to power the window air conditioner in the director of nurses office. The maintenance director said at the time of observation, extension cords were not approved for use in the facility. 3.1–19(b) K0154 Where a required automatic sprinkler system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a written policy The current fire watch policy has been revised to include the sprinkler system(s) and the proper procedure to				B. WINC	_	DDRESS, CITY, STATE, ZIP CODE		
NAJID PREFIX CEACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR ISC DENTIFYING INFORMATION) TAG REGULATORY OR ISC DENTIFYING INFORMATION) TAG STUCKTURE. This deficient practice could affect 3 residents in the lobby smoke compartment. State Staff is instructed during annual safety in-service to not use extension cords for any reason. This will be monitored by the Maintenance and Housekeeping supervisor and staff during weekly walk thru rounds so as to prevent recurrence. This is done as of 11/23/11 at 12:30 p.m., an extension cord was plugged into the cord used to power the window air conditioner in the director of nurses office. The maintenance director said at the time of observation, extension cords were not approved for use in the facility. 3.1–19(b)	NAME OF P	ROVIDER OR SUPPLIER						
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X0154 SS=F Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a written policy K0154 K0154 The current fire watch policy has been revised to include the sprinkler system(s) and the proper procedure to								
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Based on record review and interview, the facility failed to provide a written policy $\begin{bmatrix} K0154 & . & The current fire watch policy has been revised to include the sprinkler system(s) and the proper procedure to \\ \end{bmatrix}$		is out of service fo 24-hour period, the jurisdiction is notifi evacuated or an a is provided for all p the shutdown until	r more than 4 hours in a e authority having ied, and the building is pproved fire watch system parties left unprotected by the sprinkler system has					
provide a written policy include the sprinkler system(s) and the proper procedure to		Based on record	d review and	K0	154		-	12/06/2011
provide a written policy and the proper procedure to		interview, the f	acility failed to					
		provide a writt	en policy				اد	
		containing prod	cedures to be			follow when needed. (See		
followed to protect 56 of 56 attached 1 and 2)		followed to pro	tect 56 of 56			attached 1 and 2)		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	ILTIPLE CO	NSTRUCTION		(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBE	R:	A. BUIL	DING	01		COMPL	
		155719		B. WINC	}			11/22/2	U11
NAME OF F	PROVIDER OR SUPPLIER					DDRESS, CITY, STATE,	ZIP CODE		
					3623 E S				
GEORGE	E ADE MEMORIAL	HEALTH CARE CENT	ΓER		BROOK	, IN47922			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENC	IES		ID	PROVIDER'S PLAN ((X5)
PREFIX	``	CY MUST BE PERCEDED B]	PREFIX	(EACH CORRECTIVE ACT	THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORM	MATION)	-	TAG	DEFICIEN(- ,		DATE
	residents in the					policy now includ	The revised		
	automatic sprir	nkler system has t	0			process needed			
	be placed out o	of service for 4				proper applicatio	•		
	hours or more	in a 24 hour perio	d				The policy v		
	in accordance v	with LSC, Section				be revised as ne			
	9.7.6.1. LSC, 9	0.7.6.2 requires				a current and app as to prevent furt		-	
	sprinkler impai	rment procedures				·	The		
		PA 25, Standard f				Administrator or	-		
	Inspection, Tes					Maintenance sup		be	
	· ·	f Water Based Fire				responsible to ma		•	
	Protection Syst					revise the policy maintain complia		O	
	11-5(d) require					•	This is done	e as	
	-	be notified of a				of 12/6/2011.			
	-	rment and 11-5(e)						
	requires the in		,						
	•								
	alarm company								
	owner/manage								
		ing jurisdiction als	50						
	to be notified.								
	practice could a	affect all occupant	S.						
	Findings includ	le:							
		w of the facility's							
	policy and proc	edures with the							
	maintenance di	irector on 11/22/	11						
	at 3:25 p.m., th	nere was no fire							
	watch procedui	re for an out of							
	service automa	tic sprinkler							
	system. The m	aintenance directo	or						
	said at the time	e of the record							
	review, he was	not aware of the							
	requirement.								
EODY CLES	-	01.1.				D	re		12 1 - :
FORM CMS-2	567(02-99) Previous Version	ons Obsolete	Event ID: 6V	UC21	Facility II	D: 000559	If continuation s	neet Pa	ge 18 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155719		· ·	A. BUII	LDING	NSTRUCTION 01	(X3) DATE COMPL 11/22/2	ETED
		1557 19	B. WIN			11/22/2	011
	ROVIDER OR SUPPLIER	HEALTH CARE CENTER		3623 E	DDRESS, CITY, STATE, ZIP CODE SR 16 , IN47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0155 SS=F	Where a required service for more the period, the authorinotified, and the brapproved fire water left unprotected by alarm system has 9.6.1.8 Based on observing interview the farm provide a complet containing provide a complet containing provide at the containing provided at the containing provide	fire alarm system is out of nan 4 hours in a 24-hour ty having jurisdiction is uilding is evacuated or an the is provided for all parties of the shutdown until the fire been returned to service. Evation and ucility failed to elete written policy cedures to be tect 56 of 56 elevent the fire as to be placed out our hours within a in accordance with 6.1.8. LSC 19.7.1.1 health care ave in effect and supervisory in for the protection All employees shall instructed and kept respect to their	K	D155	The current watch policy has been revise include the sprinkler system(and the proper procedure to follow when needed. The revised policy now includes the addit process needed to provide for proper applications of the policy be revised as needed to main a current and applicable polic as to prevent further occurrent. The Administrator or designee an Maintenance supervisor will be responsible to maintain and revise the policy as needed to maintain compliance. Staff in-serving on revised fire watch policy of 12/8/2011.	d to s) ional or iicy. vill ntain cy, so nce. d oe	12/08/2011
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID: 6\	VUC21	Facility I	D: 000559 If continuation sh	neet Pac	ge 19 of 21

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	А. В	UILDING	01		COMPL	
		155719	B. W	/ING			11/22/2	U11
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE,	ZIP CODE		
				3623 E S	-			
		HEALTH CARE CENTER		BROOK	., IN47922			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL PLICE IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIAT	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIEN	,		DATE
		of the alarm to the						
	•	nt and response to						
		2.3 requires health						
	<u>-</u>	to be instructed in						
		de phrase to assure						
		of the alarm during a						
		the building fire						
	alarm system.							
	[·	affect all residents,						
	staff and visito	ors.						
	Findings includ	de:						
	Based on revie	w of the facility's						
	Fire Panel Mon	itor Policy provided						
	as evidence of	procedures to						
	follow in the e	vent the fire alarm						
	system was ou	t of service with the						
	maintenance d	lirector on 11/22/11						
	at 3:25 p.m., t	he policy and						
	procedure was	not complete. The						
	procedure did	<u>-</u>						
	l ·	ired such as the						
		n of a fire watch if						
		system is out of						
		r hours in a twenty						
		od, the telephone						
	I =	ovide notice to the						
		rtment and the						
	Indiana State D							
		ans by which notice						
		be provided to						
		statements that the						
								<u> </u>
FORM CMS-2	567(02-99) Previous Versi	ions Obsolete Event ID:	6VUC	21 Facility I	D: 000559	If continuation sl	neet Pag	ae 20 of 21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155719			LDING	NSTRUCTION 01	(X3) DATE COMPL 11/22/2	ETED	
	PROVIDER OR SUPPLIER	HEALTH CARE CENTER	P. (12)	3623 E	ADDRESS, CITY, STATE, ZIP CODE SR 16 5, IN47922		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	facility's staff v and designated fire watch plan director said a record review,	vere to be trained d in regard to the . The maintenance at the time of the he was not aware as had not been met.					